Priority Health	BILLING POLICY No. 110
DURABLE MEDICAL EQUIPMENT (DME) CAPPED RENTAL	
Date of origin: July 11, 2025	**Review dates: July 2026, 09/2026**

POLICY OVERVIEW

This policy outlines billing requirements for a specific category of DME for which Priority Health reimbursed according to our fee schedule.

DEFINITION

Capped rental means monthly payments for the use of the Durable Medical Equipment (DME) for a limited period not to exceed 10 months for Medicaid and Commercial plans and 13 months for Medicare plans.

MEDICAL POLICY

- Durable Medical Equipment (#91110) – reference for coverage details

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

Ownership of capped rental items: Will be transferred to the member after the capped-rental period of 10 months has been completed. If the member requires an upgrade of equipment during the capped rental period (i.e., CPAP to BIPAP), Priority Health will apply the amount already paid on the capped rental toward the balance of the upgraded item.

Transfer of capped rental equipment: If the member changes carriers during a 10-month capped rental period, a new rental period will not begin. Priority Health will allow coverage for capped rental equipment and will pay the number of months remaining on the capped rental amount up to 10 months on new members to the plans or on members who have lost a primary carrier, therefore making Priority Health their primary carrier. Ownership of capped rental items shall be transferred to the beneficiary after the capped-rental period of 10 months has been completed.

Upgraded equipment: Member requires an upgrade of equipment during the capped rental period (i.e., CPAP to BIPAP). Priority Health will apply the amount already paid on the capped rental toward the balance of the upgraded item.

Loaner equipment: Priority Health will pay for loaner equipment on member owned equipment outside the capped rental period. Payment will not be made for the rental of equipment on supplier owned equipment (within the 10-month capped rental period).

Modifiers

Services for capped rental require modifier RR for monthly reimbursement. If approved for purchase, NU modifier must be appended. See the medical policy for medical necessity requirements.

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Learn more about modifier use in our Provider Manual.

Capped Rental modifiers

- **KH**: First Month: KH is used for the initial claim or the first month of the capped rental period.
- **KI**: Second and Third Months: KI is used for the second and third months of the capped rental.
- **KJ**: Four through Fifteen Months: **For Priority Health - KJ is used for months four through ten or thirteen months of the capped rental period.**
  Note: Priority Health follows 10 months for Medicaid and Commercial plans and 13 months for Medicare plans.
- **NU**: New
- **RR**: Rental
- **BP:** The beneficiary has been informed of the purchase and rental options and has elected to purchase the item

Frequency limits

Capped rental devices should be billed with a date span that encompasses the month being billed for the DME rental. The “from” date will identify the date the item was furnished to the member, and the “to” date should reflect the last date of the date span for the item or supply. Accurately defining this date span will allow for accurate processing of the claim.

- Claims with dates of service that overlap will result in a denial.
- Supplies that are billed for a date span should also follow the “From” / “To” date guidelines.
- A Calendar Month is the period of duration from a day of one month to the corresponding day of the next month.
- To receive separate reimbursement for bilateral items, appropriate laterality modifiers must be used. Up to one unit per side, with a maximum of two rental rates within the same calendar month. Modifiers RT and LT should be submitted on separate lines for the same HCPCS code.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient’s medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

REFERENCES

- Medicare Claims Processing Manual – Chapter 20: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
07/2026	Added BP modifier and updated KJ modifier
09/2026	Policy Overview has been added. Also, clarified language and time frames for Priority Health related to modifier KJ